Home and Community-Based Infrastructure, Coordination and Choice

"Our existing community infrastructure needs to be strengthened through the addition of community-based services that will enable individuals to remain in their own community post-transition and avoid re-institutionalization."

- Strengthening the system for individuals currently being served and developing capacity to serve additional individuals in the community requires a commitment of resources from the state to ensure rates and reimbursements cover the actual cost of providing services and supports.
- The Waiver should ensure multi-year increases to rates and reimbursements (including reformulating rates where appropriate) to increase the average hourly wage paid to direct service personnel (including, but not limited to, direct care staff, front-line supervisors, qualified support professionals, nurses and non-administrative support staff) and ensure community-based providers are able to recruit and retain quality staff and reduce gaps in service needs.
- It is unclear how a uniform assessment instrument will identify the needs and wants of the entire Medicaid population, including long-term services and supports, as well as how a tool would interface with determining rates and reimbursements. Any such tool must be able to identify the needs and wants of individuals with complex medical and behavioral support needs.
- The waiver should not advocate for or prioritize managed long-term services and supports for children and adults with intellectual and developmental disabilities. Illinois continues to work towards rapid implementation of various care coordination programs and has encountered issues that have often pushed back implementation deadlines. The state is simply not ready to explore this approach.

1A. Combine and Modernize HCBS Waivers

- We see value in a conversation about eliminating barriers that may currently exist under Illinois' multiple waiver structures so that true person-centered supports can be achieved for the consumers our members serve and will serve in the future. The waiver should recommend identifying and modifying federal and state regulatory and funding barriers to providing person-centered services and supports. For example:
    - Day Habilitation/Day Training - rate methodology and regulation (59 Ill Adm Code 119)- does not provide sufficient flexibility to develop true, person-centered supports.
    - Residential Habilitation/CILA - rate methodology and regulation (59 Ill Adm Code 115) - does not provide sufficient reimbursement for nursing supports, medical and behavioral staff addition needs, and models of care for serving individuals in crisis (temporary and/or long-term).
    - Employment First - the state has provided no direction for how it will finance implementation.

- Services defined in the existing 1915(c) waivers should form the floor of minimally available services and supports to ensure continuity under the Waiver. Furthermore, we recommend including individual and group respite, and home-based services for families with children under the age of 18 with behavioral challenges as waiver funded programs.
- The Waiver should provide assurances that resources currently being invested to support individuals with intellectual and developmental disabilities and mental illnesses in the community will not be reallocated to other Medicaid populations under a single waiver. Furthermore, knowing delayed payments is a significant issue for providers, the Waiver should identify timely payment for services as a priority.
- We support identifying additional resources to reduce the waiting list and increase access to services, however, it is critically important that the waiver concept not discount the stresses insufficient resources have placed on the system for individuals currently being served.
- Outcome-based reimbursement strategies is another area of concern for the Association that requires further explanation. We caution against identifying too many specific outcome-based reimbursement strategies in an environment where we believe a rising tide would lift all boats.
- A provider assessment on waiver funded services and supports as an approach to drive additional resources into the system is one the Association has investigated in the past, but has not advanced with the Department of Healthcare and Family Services or the General Assembly. With the varied approaches states can take with respect to an assessment, this item requires further discussion before the Association could definitively adopt a position, especially given years of financial neglect of the system.

1B. - Behavioral Health Expansion and Integration

- We support utilizing evidence-based recovery models currently funded through capacity grants, such as community crisis supports, step-down and transitional living as a way to guide the system. However, we know that the continued erosion of capacity grant funds (supervised, supported, and crisis residential, psychiatric leadership, psychiatric medications, etc.) will further destabilize the system...the above mentioned programs simply would not exist without these state GRF funds. The Waiver should prioritize resources to increase access to triage, crisis stabilization, and transitional living programs as defined in the Department of Human Services Division of Mental Health's Request for Information on Specialized Mental Health Rehabilitation Facilities Comparable Services.
- We support investments in health information technology for behavioral health programs. However, this is an area that highlights questions of providers with respect to how resources would be identified and whether state systems would integrate with what is currently being utilized by many behavioral health providers.

1C. - Stable Living Through Supportive Housing

- We support prioritizing supportive housing and employment programs in the waiver application. In addition, the Waiver should consider other housing models that aid in the long-term recovery of an individual with a serious mental illness, such as scattered site projects.
- The Waiver should ensure a housing continuum of care that incorporates existing services developed by community-based mental health providers to meet specific needs in communities across the state (supervised, supported, and crisis residential as well as supportive housing). The Department of Human Services Division of Mental Health's movement to promulgate regulations around existing residential and housing models has caused concern that capacity grant funds will be diminished and residential and housing capacity will actually diminish as a result.
- We recommend prioritizing resources for outreach and engagement programs. Reimbursing community-based mental health providers to go into the community and help individuals with serious mental illnesses access services and maintain medication and treatment plans will further bend the cost curve by reducing emergency room utilization and admittance into institutional levels of care.
- While we support identifying additional state resources for supportive housing and supported employment programs for individuals with serious mental illnesses, we are interested in how a DSRIP or DSRIP-like program might be developed specifically for community-based mental health centers and how that might be funded. Bonus payments to providers that include bridge payments for housing, reimbursing providers for completing SOAR SSI applications, and/or specifying small pilot/demonstration programs that target regions/specific populations could be considered in the Waiver.

Delivery System Transformation

2A. Implement and Expand Innovative Managed Care Models

- Any substantial delivery system transformation that involves long-term services and supports should avoid shifting back to exclusively medical models of care delivery. The Waiver must include social benefit indicators (and outcome measures with financial incentives) such as habilitation, preventative health services, skill development, employment, transportation and housing supports.
- The Waiver should prioritize pilot/demonstration programs for community-based providers becoming specialty patient-centered health homes for individuals with intellectual and developmental disabilities and/or serious mental illnesses.

ID/DD Residential Habilitation Transformation - Not Referenced in the Concept Paper

- The Waiver should identify reimbursement and regulatory barriers that prevent community-based providers from downsizing facilities (ICFDD and CILA).

- With respect to ICFDD (ICF/MR) debt relief - capital investment and transition rates (or maintenance of rates) are potential ways to incentivize providers to downsize or close these facilities according to the wishes and needs of the residents. While this is an identified priority in the Department of Human Services Division of Developmental Disabilities Seven Year Strategic Plan, it remains unresolved and is a barrier.
- With respect to CILA, the rate methodology is a primary contributor to 75% of CILA packets for 6-8 bed group homes (December, 2012 data). Also, state law and regulations (59 Ill Adm Code 116) are barriers to individuals requiring injectable medications living in CILA group homes. The Waiver should prioritize rate models that incentivize providers to create residential capacity that responds to the needs and wishes of individuals currently receiving services and those who will in the future. Furthermore, the Waiver should speak specifically to regulatory barriers that must be addressed for individuals accessing CILA and those providers who support them.

Build Capacity of the Health Care System for Population Health Management

- The Waiver should identify reimbursement and regulatory barriers that cause individuals with intellectual and developmental disabilities, mental illnesses, and substance use disorders to access costlier back-end care in hospital emergency departments and other high cost settings:
    - ICFDD (ICF/MR) regulations may promote the utilization of hospital emergency departments to stabilize an individual with a medical condition or behavioral crisis due to staff support limitations and fear of costly citations from the Department of Public Health survey process.
    - CILA rate methodologies are a barrier to providing appropriate levels of nursing in current settings (medication administration issue is identified in the previous section) and certainly in smaller settings that many individuals with higher levels of need would choose.
    - The Institutions for Mental Disease (IMD) exclusion restricts access to residential treatment for individuals seeking substance abuse treatment.
- The Waiver should explore proposals for greater use of peer mentors/recovery coaches as well as potential paths to credentialing.

3A. Wellness Strategies

- We agree it is important to identify prevention and wellness strategies to help individuals enrolled in Medicaid, where appropriate, to better manage their health. However, we caution against strategies that don't take into consideration the complex medical and behavioral support needs of individuals with intellectual and developmental disabilities and/or mental illnesses. We caution, again, the mindset of a medical model versus a developmental model for persons with

intellectual/developmental disabilities. This would be considered regressive policy for supporting individuals with disabilities.

- The Waiver should prioritize increased resources for addiction prevention, including investment in Community Intervention and Early Intervention addiction prevention programs.

21st Century Health Care Workforce

4A. Graduate Medical Education

- With respect to a Medicaid GME program, the Waiver should prioritize strategies to increase the number of psychiatrists, other mental health professionals, as well as primary and specialty care physicians that are trained to care for persons with intellectual and developmental disabilities.
    - Evaluation of Phase I of the Integrated Care Pilot Program has shown no improvement over traditional Fee-for-Service in terms of access to primary care and specialty care doctors for individuals with intellectual and developmental disabilities.
    - Access to psychiatry for adults is a major issue in many regions of the state, even more so for children and adolescents.

4B. Loan Repayment

- The Waiver should prioritize a broad range of loan repayment programs for a broad range of professionals working in community-based settings, including Qualified Mental Health Professionals (QMHPs), Qualified Intellectual Disability Professionals (QIDP), psychiatrists, psychologists, and nurses.

4C. Other Workforce Training

- Consistent with previous comments, the Waiver should prioritize a multi-year commitment to increase the average hourly wage paid to direct service personnel (including, but not limited to, direct care staff, front-line supervisors, qualified support professionals, nurses and non-administrative support staff) and ensure community-based providers are able to recruit and retain quality staff and reduce gaps in service needs.

General Comments:

- The Waiver Concept Paper has given self-advocates, community-based providers, and other stakeholders the strong impression the state intends to pursue a medical model of care for the entire Medicaid population, even though it is expected to include long-term services and supports. Prior to or with publication of the draft waiver application, we recommend the state provide a concept paper that similarly outlines how Medicaid long-term services and supports fits within the *Path to Transformation*.

- The Waiver should provide assurances that the medical and long-term service and support needs of individuals with intellectual and developmental disabilities, mental illnesses, and/or substance use disorders are being prioritized and that mechanisms for further rationing care are not introduced.
- A consistent and significant theme in our comments involves reimbursements. Since 2009, state appropriations for community-based services were significantly reduced, leading to long payment delays to community-based providers and the practical elimination of services to non-Medicaid eligible individuals. Recent investments in the community have come as a result of court ordered consent decrees, which have done little to address the service needs of individuals currently being served in the community. In addition, several workgroup reports and studies have provided recommendations with respect to updating and reformulating rates and reimbursements. Therefore, to show a commitment to individuals currently being served and the professionals that support them, the Waiver must prioritize a commitment to rates and reimbursements for long-term services and supports that reflect the high quality system of choice both the Administration and the community wish to build.
- The lack of detail within the Concept Paper in areas that involve financing (DSRIP, pools of resources, expansion of services, CNOMs, etc.) has generated more questions than comments/recommendations. The net effect is skepticism that enough savings will be realized in other areas of the Medicaid program to shift resources to clear areas of need to meet the goals of the Waiver.
- Whether in the Waiver, or as a statement from the Administration, it should be clear that the Waiver does not prohibit the state from prioritizing additional GRF investments in community-based services and supports. The resource needs in the community-based system are too great to give advocates, providers, and other stakeholders the impression that the state does not have an obligation to address them.